Iowa Department of Human Services
Mental Health and Disability Service System Redesign
Mental Health Workgroup
October 4, 2011

Briefing Paper

Part I: Summary of Recommendations to Date
Part II: Workforce Development

Part I:

Over the first three meetings, the Mental Health Workgroup has discussed a range of topics including Outcomes, Performance Measures and Core Services necessary to deliver a system of comprehensive, evidence-based services to Iowans. Part I summarizes recommendations that have evolved from the discussions. Part II addresses Workforce Development issues confronting Iowa that will be discussed in the next meeting.

DRAFT Recommendations from Mental Health Workgroup:

1. Eligibility:

   The Workgroup recommends the following criteria for general eligibility for mental health services in the State of Iowa. Other insurance coverage (e.g. Medicaid, Medicare, other 3rd party) will have unique eligibility criteria. In addition, people will receive specific services depending on certain criteria including level of functioning, severity of symptoms and other needs, and by funding source (i.e. federal block grant).

Age:	An individual must be 18 years or older.
Residency:	An individual must be a Resident of the State of Iowa.
Financial Eligibility:	An individual must have an income equal to or less than one hundred fifty percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human services. A contracted provider shall apply a copayment requirement for a particular disability service to a person with an income equal to or less than one hundred fifty percent of the federal poverty level. The copayment amount shall be established with rules adopted by the commission applying uniform standards with respect to copayment requirements. A person with an income above one hundred fifty percent of the federal poverty level

may be eligible subject to a copayment or other cost-sharing arrangement subject to limitations adopted in rule by the commission. A person who is eligible for services must apply for and utilize other potential sources of insurance or financial coverage for services prior to using public funds.

Diagnosis: An individual must have or have had at any time during the past year a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness.

Level of Functioning: An individual must be experiencing functional impairment which substantially interferes with or limits one or more major life activities. A functional assessment must be documented by an appropriately licensed or credentialed professional in the clinical record.

Following the Workgroup meeting on 9/20/11, a subcommittee met to discuss functional assessments. The sub-committee recommends to the Workgroup that a standardized functional assessment tool, such as the LOCUS, be used by all contracted providers who receive Medicaid and non-Medicaid funds. Data from the functional assessment shall be submitted to the State and then shared as appropriate with the Regional entities. The purpose of the standardized assessment includes the following:

- The tool can be used as an authorization for services to support the recommendation for a particular service. The Regional entity can verify that an assessment has been done and that the service a consumer is receiving or assigned to is consistent with the level of care identified in the assessment. For example, the tool may indicate a level of service equivalent to Outpatient Counseling. Thus, placement into Assertive Community Treatment would be inappropriate and better utilized by a person in need of that level of service, unless a more detailed clinical assessment justifies the need for the more intensive level of care.
- Aggregate data collected from the report can be used in a Dashboard Report to support outcomes. For example, progress or regression can be identified over time on an individual, regional, and a statewide systems level.
- At a state level, aggregate functional assessment data would allow for analyses of levels of service across regions vs. expected need.
- Aggregate data can be used to inform policy makers and payers regarding the general need for particular levels of services. For example, if a region didn't have access to an ACT team, it would be expected that there would be more discrepancies between the

LOCUS recommended and actual levels of care, with more patients being in residential settings. This would help support the development adequate array of services to match the needs in each region.

The tool should be administered at set intervals, and more frequently as needed to support clinical decision making for levels of care.

2. Outcomes and Performance Measures:

The workgroup felt strongly that outcomes should be clear and understandable to a wide variety of audiences. The Iowa Plan contractor and regional entities should be required to monitor and evaluate similar outcomes and performance indicators.

Recommendation: The group suggested that outcomes be measured in critical areas such as the following core service domains:

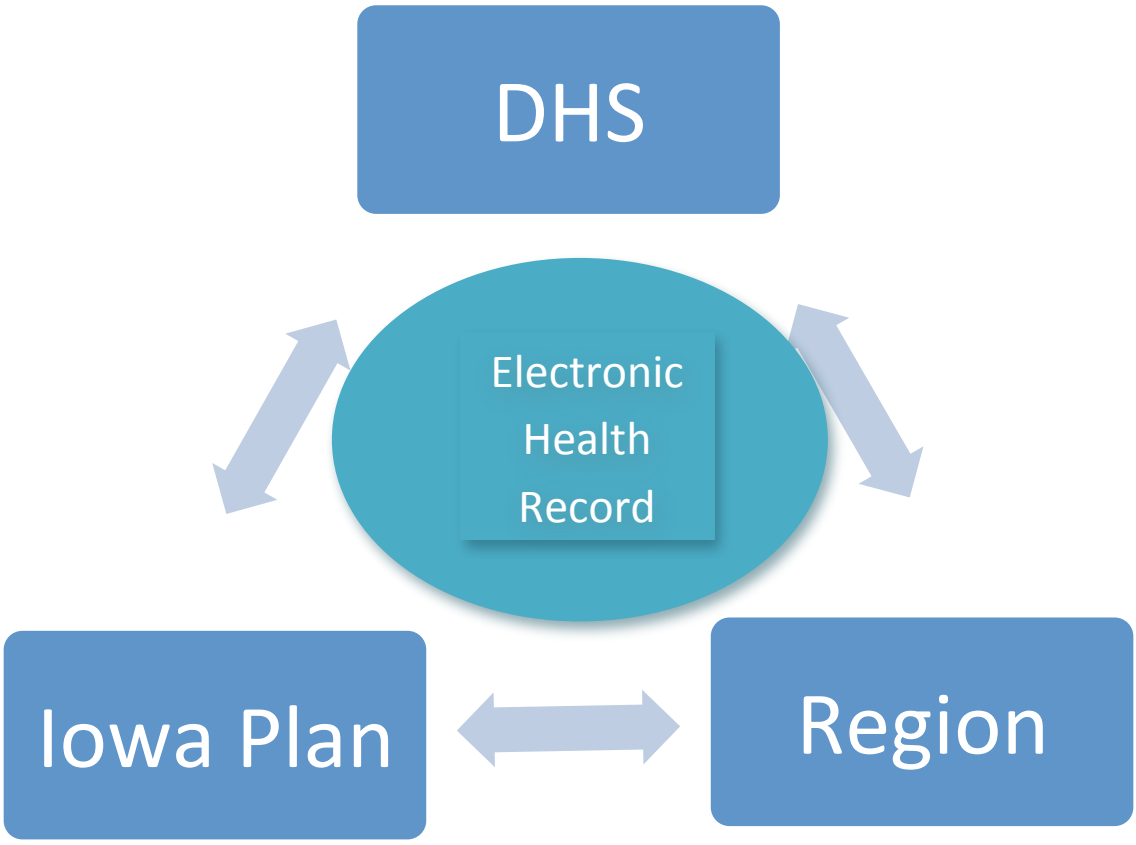
- Crisis Services:
- Mental Health Treatment:
- Mental Health Prevention:
- Community Living:
- Employment:
- Recovery Supports:
- Family Supports:
- Health and Primary Care Services:
- Justice Involved Services:
- Workforce Development[1]

Data collection must be tied to outcomes. Data must also have relevance to each of the players in the system, including the Department, the Medicaid contractor and the Regional Entities. The workgroup noted that much data is collected in the system, but the general consensus is that it is not used to guide decision making. Contributing to this is the lack of capacity at DHS due to relatively small numbers of staff. There was discussion regarding whether data for performance indicators should be handled by DHS or by the Iowa Plan contractor and regions. A singular repository at the State level is desirable. DHS currently is able to access data about Medicaid recipients. Ability to access similar data about non- Medicaid services including but not limited to dashboard reports is also necessary to provide clarity of services delivered in the state as a whole.

[1] Workforce Development was added to the Outcomes list because the serious workforce issues confronting Iowa.

The following diagram below demonstrates the interaction of data. Ultimately, as Electronic Health Records (EHR) stand up, each entity that needs data can extract it for its purposes from the EHR. Since this is still a few years away from becoming a reality, the Department should assist in developing web-based systems at the regional and provider level that can support the seamless input and output of data. A basic diagram for an integrated data delivery system is provided below, and demonstrates that when an integrated electronic Health Record is developed, each of the component parts of a system can extract and utilize the data for its purposes.

Integrated Data Diagram:



Recommendation: The Workgroup further recommends that a Outcomes and Performance Measures Committee be established to continue and finalize this work beyond the Redesign process.

The first responsibility of the committee should be to identify specific outcomes and performance measures to be measured across the system. To the extent possible, there should be consistency across disability groups. This Committee should also include an evaluation of current data collection requirements that should be eliminated because they may be administratively burdensome or have little relevance to outcomes or other reporting requirements (e.g. legislature, federal block grants). A summary of the various data elements that are currently captured by DHS or other entities is attached.

Once the outcome and performance measures are established, the MHDS Commission and Department should monitor, evaluate and report the progress toward system outcomes on at least an annual basis as well as any recommendations for improvement or modification.

The committee should be composed of DHS employees and stakeholders with expertise in quality improvement, including Magellan, the Olmstead workgroup, University of Iowa, consumers and family members.

3. Core Services:

The Workgroup identified a broad list of services and programs that are important to meeting the needs of consumers and families, and that each region must ensure that evidence-based services within each of the following Core Service Domains.

Recommendation: The Core Service Domains identified by the Workgroup that should be available in each region include:

- Crisis Intervention and Diversion Services
- Mental Health Treatment
- Mental Health Prevention
- Community Living
- Employment
- Recovery Supports
- Family Supports
- Health and Primary Care Services
- Justice Involved Services

Regarding services, there are more traditional core services such as Outpatient Counseling or Medication Management that are necessary, but there are also other services that are as important to an individual's recovery, nonetheless. These may include, for example, things like rental assistance, transportation, or homemaker services. The critical concept is that a successful system ensures that there is a foundation of core, evidence-based services and programs that deliver a cadre of flexible, individualized services.

The Workgroup recommends that each region should ensure that evidence-based services within Core Service Domains are available. Within each Domain are specific Core Services that should be available through regional services and the Iowa Plan. Some of these services are specific services, such as Medication Management, while others are programmatic in organization, such as ACT, and deliver a range of care management and treatment services.

Furthermore, there are some services that are not covered by Medicaid due to program requirements, but nevertheless, are important. For instance, in a Community Support Services model, a service or function such as rental assistance or paying for food on an emergency basis may not be covered by Medicaid, but are worthy of reimbursement as compared with costly alternatives (e.g. homelessness). Therefore, Regions should have the flexibility to pay non-mandatory, yet essential, "services" as needed. Rather than include or exclude specific services that should be considered as reimbursable, the workgroup suggests that the following criteria be considered by regions when reimbursing for services:

1. A person-centered planning process should be utilized to justify the need for particular services, and
2. The services should be recognized as having an evidence-base to support them.
3. Conversely, regions should move away from reimbursing services that do not have an evidence-base or are inconsistent with Olmstead principles.

Recommendation: The Workgroup felt that moving toward the availability of statewide evidence–based practices and away from services that do not have a strong evidence base. This is consistent with Olmstead principles, serving people in the most integrated settings possible, will have the greatest return on investment, and enable the State to rebalance or reallocate funds. This includes the recognition of serving people in smaller, non-congregate care settings and leveraging Medicaid to the extent possible. This process will take time, and, ultimately, financial incentives should be built into rates or contracts to force this transition.

Accordingly, the Workgroup recommends that as regions are developed, they demonstrate a business plan for how they will implement core services in each of the Domains over a five year period. The Workgroup felt this should be developed at a regional level due to the variability in regional makeup. Regional phase-in schedules should demonstrate how services that will yield the greatest return on investment will be phased in earlier in the process.

Recommendation: As part of the discussions on core services, specific services were discussed. In addition to the development of a continuum of available, flexible services in each region, the Workgroup recommends the following services be created in each region. Each service should be capable of working with individual who present with multi-occurring disabilities and those with more specialized needs (e.g. older adults).

Peer Delivered Services: The use of peers in delivering services is recognized as an evidence-based practice in producing positive outcomes for consumers, and has a secondary gain of expanding the workforce necessary to meet the demand. Each region should establish one or more self-help centers. The self-help centers should be managed by a consumer program manager at a gainful salary. The self-help center should consist of a governance structure that is composed of more than 50% consumers. The self-help center should also build in wellness and supported employment functions to the extent possible.

Further, peers should be required to be hired in each of the different programs supported by Medicaid and non-Medicaid funds.

Crisis Services: Each region should have Psychiatric Emergency Screening (PES) services that contain a range of crisis intervention and diversion services. PES services can be organized and administered by a single provider within a region or through a coordinated network of crisis response services as long as the core functions exist.

- 24/7/365 crisis hotline. The hotline should be answered locally within a region. However, for ease of access to the general public, a single hotline number can be established that automatically bumps to the local area code that the individual in crisis is calling from so that it is answered by PES in close proximity to the caller.
- Mobile Response: The PES must have 24/7/365 mobile response with the goals of, first, mitigating the crisis and diverting from inpatient hospitalization; second, facilitating inpatient hospitalization when civil commitment is necessary; and, third, ensuring linkage with the appropriate follow-up services. Mobile Response may be initiated by PES when a person calls, or may be requested by local police. In situations where Mobile Response is unavailable, a person may go to or be brought to the PES program for evaluation. PES program should have capacity and/or access in the local emergency room, as well as, in non-hospital based settings.
- Crisis Residential: Each region should have short-term (0-7 days) crisis residential capacity in an unlocked setting. The purpose of this voluntary program is to help a person stabilize a psychiatric crisis and to avoid an unnecessary inpatient stay. Crisis residential programs may be staffed with consumers. Crisis Residential is for people who are experiencing an acute episode such that if this intervention is not in place, they would otherwise meet inpatient

civil commitment criteria. Crisis Residential services may be provided in a person's place of residence with intensive on-site, wraparound support or in a residence designed for this purpose. The residence should serve less than six people at any given point in time. If not directly managed by the PES program, it should work closely with the Crisis Residential program to ensure the efficient use of the beds. DHS should establish standards for Crisis Residential to ensure consistency across the State.

- Facilitate civil commitment process and inpatient treatment when necessary.

Sub-acute Services: The Workgroup felt that a range of sub-acute residential services should be available in each region. Sub-acute services should be defined as a residentially based service, either a) in the person's home, or b) in another residential setting. Sub-acute services have the ability to provide up to 24 hour on-site support with a range of psychiatric and medical treatment and support services. Eligible consumers should not require inpatient care, but their level of functioning is such that they require more intensive supports to remain in the community. Sub-acute services are intended to be temporary in nature with average length of stays up to thirty days with longer lengths of stay requiring authorization from the region. Sub-acute services are ideally in settings with fewer than six people.

Jail Diversion: Each region should develop an provide access to a Jail Diversion program and a Crisis Intervention Team (CIT) based upon the principles in the Memphis, Tennessee CIT model. DHS should lead development of jail diversion. Using the Sequential Intercept Model, jail diversion services should assist along the various points of intersection with the criminal justice system.

Assertive Community Treatment (ACT): Each region should have at least one ACT team that can serve Medicaid and non-Medicaid eligible individuals. Regulations that define the scope of ACT services should be established by DHS to ensure consistency throughout the state and fidelity to the ACT model.

Community Support Services/Supportive Housing: Supporting an individual in their own residence, whether it is with family, a small shared living residence or their own home/apartment is cost effective, consistent with Olmstead, and desired by consumers. An array of flexible, recovery-oriented support and care management services should be available through a team of professionals, paraprofessionals and consumers. In this program, housing is not contingent upon receipt or compliance with services. This model often meets the needs of consumers who are very independent and those who are often difficult to serve in group settings, but can succeed in community living arrangements with intensive wraparound supports. DHS should establish standards for a Community Support Service/Supportive Housing service to ensure a level of consistency throughout Iowa.

Health Homes: Section 2703 gives states the ability to submit a State Plan Amendment to create Health Homes. CMS will pay for 90% of the costs of care management for the first two years.

The Iowa Medicaid Enterprise (IME) should submit a SPA to develop Health Homes in each region of the state for the top 5% of high cost utilizers of psychiatric and medical services. Health Homes should be available to Medicaid and non-Medicaid individuals who fall into this category.

Supported Employment and Supported Education: Obtaining gainful, meaningful employment is critical to a person's recovery and enables individuals to contribute to the system. Each region should establish these programs, and mechanisms to coordinate with the Iowa Departments of Labor and Education, and at the local level with employers, colleges and universities, should be established. The Workgroup did not recognize sheltered workshops as Supported Employment.

Family Support Services: Family psycho-education is considered a best practice. Regions should create mechanisms for families to receive support, skill building training and other supports to help cope with the illness of their loved one and to assist in their recovery.

Part II: Workforce Development

The challenge of having a sufficient workforce is not unique to Iowa. Insufficient numbers of staff combined with existing staff whose knowledge and experience are inadequate to meet the needs of service recipients has created a national workforce crisis in behavioral health. For most mental health positions, there are severe workforce shortages, and nearly all of Iowa's counties are designated as shortage areas in Mental Health Care Health Professional Shortage Areas (HPSA).[2] Iowa consistently ranks toward the bottom in terms of the availability of psychiatrists and psychologists. The workforce crisis is especially profound in rural areas[3], and with children, youth and older adults, and on issues pertaining to co-occurring disorders, trauma-informed care, and cultural competence.

The Annapolis Coalition was established to address the workforce development issues confronting the country. In 2008, the Annapolis Coalition produced a report, following its work in Iowa, addressing Iowa's workforce challenges, and crafted recommendations and a framework for Iowa to begin to address its workforce challenges. The report is attached, and the Workgroup should consider the recommendations made in that report.

[2] Center for Health Workforce Planning, Bureau of Health Care Access, Iowa Department of Public Health 2006 Report, Iowa's Mental Health Workforce.

[3] More than 85% of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001), and they typically lack even a single professional working in the mental health disciplines.

Two central recommendations came from the report that if implemented can help establish the foundation and framework for addressing the multitude of workforce issues:

1. The creation of a Mental Health and Disabilities Training Institute
2. The creation of an Iowa Behavioral Health Workforce Collaborative

Each of these initiatives began some work, at least conceptually, but never materialized. However, establishing working functions such as these will allow for an on-going comprehensive approach to addressing the significant and complex workforce issues confronting Iowa, including recruitment/retention and training/educational strategies. The authors then went on to highlight six overarching areas that can result in an improved workforce for Iowa:

1. Increase the use of peer supports and peer operated services.
2. Enhance clinical competence through strengthened infrastructure.
3. Systematically prepare the system to develop, implement and sustain evidence-based practices for Iowa.
4. Provide incentives for recruitment and retention of behavioral and developmental specialists.
5. Increase opportunities for integration of behavioral and primary care.
6. Systematically evaluate the effectiveness of Iowa's behavioral and disability workforce efforts.

Higher Education: Preparing, recruiting and retaining professionals in Iowa's workforce is crucial. The report made several recommendations that can help bridge higher education, various State agencies and providers in building and sustaining Iowa's behavioral health workforce. Among these include:

Psychiatrists:

> Resident Retention: With so few Iowa medical students focusing on psychiatry, the state would increase their chances of retaining psychiatrists by focusing on residents rather than medical students. With only one option for residency placement in psychiatry, medical students interested in pursuing psychiatry who graduate from one of Iowa's two medical schools are likely to find residencies out-of-state. This out-of-state placement is often a better option than a residency position at the medical school from which the students graduated, as it provides more breadth in training and exposure to different models and theories for treatment.
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> Loan Repayment/Forgiveness: Residents might be encouraged to remain in Iowa following graduation and psychiatry medical students might be encouraged to return if there was a financial incentive for doing so. According to the American Association of Medical Colleges, the average educational debt of the 87% of 2006 graduates who carried outstanding loans was $130,571. In addition, 40% of 2006 graduates had non-educational debt, averaging $16,689. One way to increase the number of Iowa psychiatrists might be to offer loan repayment programs to offset some of their accrued educational debt. Individuals can be required to work in the Iowa system for a period of time in exchange for some amount of student loan forgiveness or else have to repay the funds.

Rural-Focused Training Opportunities: Iowa needs to offer rural-focused residency opportunities, which provide much needed exposure and training in rural mental health issues. The University of New Mexico Center for Rural Community and Behavioral Health instituted the Rural Psychiatry and Behavioral Health Training Program[4] to provide continued and increased opportunity for rural residency rotations in adult, child, geriatric and addictions fellowship programs; and to offer an opportunity for the development and integration of a rural interdisciplinary behavioral health training rotation(s) in other fields: psychology, social work, nursing, and physicians assistants. In this program, rural track residents spend one to two days/week for 6 months to a year in designated sites throughout New Mexico. Possible rotations are in Primary Care Sites as well as Community Mental Health Centers, with training sites in numerous predominantly Native American and/or Hispanic communities throughout the state. Rotations are funded through the New Mexico Department Human Services, Behavioral Health Services Division and the New Mexico Children, Youth and Families Department, and focus on topics such as: direct care, services research, mental health policy, Native American behavioral health programs, and program evaluation,

Psychologists:

Increase Internship Opportunities: Psychologists must complete pre-doctoral internships as a part of their graduate training. However, there are only 3 sites in Iowa that offer accredited internship programs: the University of Iowa Counseling Service, the Iowa Sate University Student Counseling Service, and the VA Central Iowa Health Care System in Knoxville[5]. This lack of internship training sites in the state decreases Iowa's opportunities to bring in and retain out-of-state psychologists, as well as to retain psychology Ph.D. graduates. In 2007, over 30% of psychology students were not matched for an internship program, although only 10% of internship programs failed to get a psychology intern[6]. Even if some of the unmatched students later took internships in the 10% of programs without interns, there were still 546 students who did not obtain internships in 2007. By adding more internships sites, particularly in rural areas, Iowa could capitalize on the overabundance of well-trained psychologists to supplement its mental health workforce.

PsyD Program: One possible solution to Iowa's psychologist shortage would be to offer a PsyD program at one of the public universities. In contrast to PhD programs, PsyD programs train psychologists to be practitioners rather than scientists. PsyD programs typically enroll three times the number of doctoral students that PhD programs enroll, although PsyD programs offer less financial aid[7]. Another way to increase the number of licensed psychologists in Iowa would be to offer more opportunities for internships. Bringing in psychologists from out-of-state may increase the likelihood that the psychologists will become licensed in Iowa. Iowa's current

[4] http://hsc.unm.edu/som/Psychiatry/crcbh/rural.shtml
[5] American Psychological Association Office of Program Consultation and Accreditation, http://www.apa.org/ed/accreditation/interni.html
[6] 2007 Association of Psychology Postdoctoral and Internship Centers Match Statistics, http://www.appic.org/match/5_2_2_1_9_match_about_statistics_general_2007.html
[7] Mayne, T. J., Norcross, J. C., & Sayette, M. A. (1994). Admission requirements, acceptance rates, and financial assistance in clinical psychology programs: Diversity across the practice-research continuum. *American Psychologist, 49*, 806-811.

internship options include only one hospital, and two university student health clinics. Offering internship opportunities in other hospital or clinic locations, particularly in rural areas, would likely bring more licensed psychologists to Iowa communities.

Advanced Registered Nurse Practitioners (ARNP):

Increase Distance Learning Opportunities: The psychiatric training program at the University of Iowa College of Nursing is geared toward practicing psychiatric nurses throughout the state. One way to increase the number of ARNPs with psychiatric specialties would be to offer distance learning options for practicing psychiatric nurses. If the course work could be completed online, practicing nurses could work toward certification from their homes during off hours, without having to travel or interrupt their workdays. This transition to an online, web-based format for course work would be particularly helpful in increasing the number of ARNPs with mental health specialties in rural areas, which are located furthest from the University of Iowa's psychiatric training program.

Marriage and Family Therapists:

Increase Enrollment. The University of Iowa will need to increase the enrollment of students in its marital and family therapy program, and retain its graduates, in order to build up its licensed marital and family therapist workforce.

Peer Workforce Opportunities: The development and use of Peers in the delivery of services has been demonstrated as an effective workforce development strategy that yields positive outcomes. Iowa does use Certified Peer Specialists and should continue to encourage the use of peers in the delivery of nearly all services. In Iowa, as in other states, Peers remain a largely untapped resource. The State can partner with universities and colleges to encourage peers to enroll in traditional majors (e.g. social work). The University of Medicine and Dentistry in New Jersey, for example, offers certificates and an Associate's degree through PhD in Psychiatric Rehabilitation, and has many consumers enrolled. The State can also create certificate curriculums/programs that can be used as recognized credentials to work in various programs. Some programs tailor the curriculum so that students, including peers, can become credentialed as Certified Psychiatric Rehabilitation Practitioners (CPRP), a rigorous, recovery-oriented credential.

Among the recommendations made in the 2006 report, *Iowa's Mental Health Workforce,* the Iowa Department of Public Health offered the following additional recommendations for improving Iowa's mental health workforce:

- That legislators determine ways to provide incentives such as loan repayments to graduates and new hire assistance to potential employers of Iowa mental health graduates who practice in the state.

- That licensure boards review the scope of practice, educational requirements including internships, licensure procurement processes, and procedures for endorsement of out-of-state licensees in order to facilitate timely entry into practice.

- That practice and education develop collaboratives that expand local opportunities for clinical experiences leading to licensure and/or certification.

Rural Workforce Strategies[8]:

The Annapolis Coalition report made several recommendations specific for rural communities, including "Grow Your Own" initiatives that are developed locally and involve the input from key stakeholders. Others included:

- Increase mental health literacy in rural communities via educational campaigns;
- Increase behavioral health career information and recruitment efforts in middle schools and high schools;
- Facilitate partnerships between higher education, public mental health system, and local community
- Recruit people living in rural areas into behavioral health careers and utiilize incentives (e.g., loan repayment) to increase likelihood that they will return to their community;
- Increase rural training opportunities;
- Utilize distance technology to support and enhance education and training opportunities, access to providers in urban areas, and supervision of providers in isolated areas;
- Maximize natural community supports including identifying the best use of paraprofessionals and mid-level professionals to support workforce needs;
- Market behavioral and other health job opportunities to broader market (e.g., non traditional populations such as seniors, veterans);
- Develop a career ladder and articulated pathways to allow people choices along the behavioral health professional spectrum;
- Increase financial incentives for those who choose to practice in rural communities for an extended period of time; and
- Create applied educational and training programs that translate into a job in the workforce system.

Additional Recommendations in the Report inlcude:

1) One solution to the rural workforce problem in Iowa would be to expand the use of paraprofessionals to provide mental health services to rural populations. Alaska has implemented a certificate program for training paraprofessionals, whereby students meet for 1-3 weeks of intensive course work each semester to work toward an Associate of Applied Sciences Human Services degree (see http://www.uaf.edu/rhs/). The certificate program could be implemented in online courses through Iowa's community college network. Each of Iowa's 15

[8] Excerpted from The Annapolis Coalition/WICHE report on Iowa's behavioral health workforce.

community college districts offers distance learning options through online courses. These distance learning options may be ideal for rural individuals interested in becoming mental health service providers without having to travel large distances to attend courses.

2) Seek additional funding from the United States Department of Agriculture (USDA Rural Development Telecommunications Program: Distance Learning and Telemedicine Program) to support telehealth technology infrastructure and development. A rural-focused state plan should be developed to identify specific uses of potential grant funds.

3) Increase training to primary care providers. Primary care providers serve as the main entry points into the mental health system for rural citizens. Increasing primary care providers' knowledge of common mental health illnesses may increase early detection of mental health problems, as well as early referrals to mental health specialists, thereby limiting progression of the mental illness. Increasing primary care provider knowledge can be accomplished with targeted training on mental health issues and ways to identify them in the primary care setting. A great resource for such training is available through the MacArthur Initiative on Depression and Primary Care (http://www.depression-primarycare.org/).